commercially canned foods. Nevertheless, the ultimate "fall of botulism" may be in the distant future, as it depends on education of the home canner, a continuing public health challenge.

MICHAEL H. MERSON, MD
EUGENE J. GANGAROSA, MD
V. R. DOWELL, JR., PH D
U.S. Department of HEW, Public Health Service, Health Services and Mental Health Administration, Center for Disease Control Epidemiology Program, Atlanta

REFERENCES

1. Werner SB, Chin J: Botulism—Diagnosis, management and public health considerations (Information). Calif Med 118:84-88, May 1973
2. Center for Disease Control: Morbidity and Mortality Weekly Rep 22(7):57, 1973
3. Center for Disease Control: Morbidity and Mortality Weekly Rep 22(10):87, 1973
4. Center for Disease Control: Morbidity and Mortality Weekly Rep 22(13):115, 1973
5. Center for Disease Control: Morbidity and Mortality Weekly Rep 22(19):161, 1973
6. U.S. Department of Health, Education, and Welfare: Botulism in the United States—Review of cases 1889-1969, Handbook for Epidemiologists, Clinicians, and Laboratory Workers, 1970
7. Craig JM, Iida H, Inoue K: A recent case of botulism in Hokkaido, Japan. Jap J Med Sci Biol 23:193-198, 1970
8. Fukuda F, Kitato T, Fanikawa H, et al: An outbreak of type B botulism in Miyazaki Prefecture. Jap J Med Sci Biol 23:243-248, 1970
9. Cherington M, Ryan DW: Treatment of botulism with guanidine—Early neurophysiologic studies. N Engl J Med 282:195-197, 1970
10. Center for Disease Control: Morbidity and Mortality Weekly Rep 22(8):69, 1973
11. Koenig MG, Spickard A, Cardella MA, et al: Clinical and laboratory observations on type E botulism in man. Medicine 43: 517-545, 1964
12. Sakaguchi G: Type E *Clostridium botulinum. In* Riemann H (Ed): Foodborne Infections and Intoxications. New York, Academic Press, 1969, pp 353-354
13. Meyer KF: The rise and fall of botulism (Editorial). Calif Med 118:63-64, May 1973

Sickle Cell Trait Hematuria

TO THE EDITOR: Allow me to make some comments regarding a case report of a patient with sickle cell trait hematuria in the June 1973 issue of CALIFORNIA MEDICINE, presented by Doctors Hoffman and Zucker. They described the use of epinephrine during selective renal angiography in order to diminish the patient's hematuria. In reading the case history, it is apparent that the patient received at least two units of blood and apparently significant intravenous hydration during the patient's illness.

In view of the fact that "modified exchange transfusion and hydration" is the recognized standard treatment of sickle cell trait hematuria at this time, it is puzzling to me how the authors can definitely say that the injection of the epinephrine into the involved kidney was the real reason for the diminution of the bleeding. The patient presented was similar to one I recently treated at Kaiser Foundation Hospital, with simply modified exchange transfusion and hydration. Several days after the last unit of blood was administered, the hematuria cleared completely and has not recurred three months hence.

It should be remembered that nephrectomy for hematuria of sickle cell trait is practically never indicated, and certainly should be resorted to, only in the last resort, since it is not an infrequent occurrence for the patient to bleed first from one kidney, and then at some later date from the other kidney. One thing that is certainly worse than a young patient with sickle cell trait hematuria is a young patient with sickle cell trait who has no kidneys.

HARRY J. CAMPBELL, MD
Department of Urology
Southern California Permanente Group
Panorama City

The Authors' Reply

TO THE EDITOR: In response to Dr. Campbell's comments in which he ascribed the cessation in bleeding in our patient to transfusion and hydration, there are several points on which we would take issue.

1. Our patient received a total of two units of whole blood separated by 24 hours. This would hardly represent a modified exchange transfusion in which fresh blood or packed cells in quantities far exceeding two units is administered over a two- to four-hour period.

2. Dr. Campbell remarks that our patient received "apparently significant intravenous hydration during the patient's illness." This must be pure speculation on his part since intravenous or even oral hydration was not mentioned in our case report.

3. To state that "modified exchange transfusion and hydration is the recognized standard treatment of sickle cell trait hematuria" is surely an overstatement. It is recognized that spontaneous remission of hematuria is a frequent occurrence. Treatment with distilled water hydration and urinary alkalinization has been promoted recently.[1] The use of epsilon aminocaproic acid (a urokinase inhibitor) has also been introduced as a possible mode of therapy.[2] Exchange transfusion has been used in pregnant women with sickle cell disease.[3] Obviously no one treatment is the accepted treatment for hematuria in sickle cell disease or trait. We have merely introduced another possible treatment.

We fully realize that the cessation of the hema-

turia in our patient could have been spontaneous and fortuitous as it could be in those cases where other modes of therapy have been attributed the success. The only method in which one could be sure as to the efficacy of our technique would be to demonstrate the bleeding point angiographically, infuse the kidney with epinephrine, and then reinject with contrast media to determine if the bleeding point had ceased. As stated in our article, the hazard of reangiography is that this may exacerbate the bleeding since the contrast media is a vasodilator. However, perhaps this is warranted to absolutely prove or disprove the efficacy of the technique. A second course of epinephrine could be given.

In response to Dr. Campbell's plea to save nephrectomy as a last resort, I believe if he would reread our article carefully he would find that the genesis of this new technique was because we were striving to avoid nephrectomy.

RICHARD B. HOFFMAN, MD
MILTON O. ZUCKER, MD
Lynwood

REFERENCES

1. Knochel JP: Hematuria in sickle cell trait. Arch Intern Med 123:160-165, Feb 1969
2. Immergut MA, Stevenson T: The use of epsilon amino caproic acid in the control of hematuria associated with hemoglobinopathics. J Urol 95:110-111, Jan 1965
3. Ricks P: Further experience with exchange transfusion in sickle cell anemia and pregnancy. Am J Obstet Gynecol 100: 1087-1091, Apr 1968

Pinpointing Preceptorships

TO THE EDITOR: At the University of California, Davis, School of Medicine, the Department of Family Practice offers electives whereby a medical student can work in the office of a physician in private practice. This physician is the medical student's preceptor. In the past, the Department of Family Practice had a listing of available preceptorships in California. Many of these preceptorships were in small towns and/or remote areas of California. Thus the medical student often had no idea where his preceptorship was located. I suggested that the Department of Family Practice obtain á large map of the State of California and place pins on the map wherever a preceptorship was located. Subsequently, medical students have found it much easier to determine exactly where their preceptorship is located.

JEFFREY L. CHIN
Fourth-Year Medical Student, Class of 1974
University of California, Davis, School of Medicine

Hemolytic Disease Reporting

TO THE EDITOR: In the recent report by Hawes and Mordaunt on two years' experience with Rh hemolytic disease reporting (Calif Med 118:28-32, May 1973) it is regrettable that no reference is made to the extensive studies which led directly to the legislation that made their report possible. These studies were reported in detail in CALIFORNIA MEDICINE (104:81-88, Aug 1966) and represented a tremendous contribution in time and effort by many California physicians, CMA staff and members of the State Department of Public Health. The reduction in deaths due to Rho (D) hemolytic disease of the newborn in California should very likely be attributed as much to these efforts as to the legislation which resulted, on which the Hawes-Mordaunt report is based.

KEITH P. RUSSELL, MD
Los Angeles

On Throw-aways and Such

TO THE EDITOR: For some time I have been troubled by the hundreds of pounds of unsolicited samples, advertisements, "throw-away journals" and various "get rich quick schemes" which arrive in my mail each year. I was pleased to find that the AMA is willing to take my name off the master promotional mailing list at my request. I would urge other physicians who are concerned about the loss in tax dollars through subsidized bulk mailing, not to mention the loss of trees to provide paper for unwanted material, to write to Mr. Robert A. Enlow, Circulation and Records Department, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

JOHN C. BOLTON, MD
San Francisco